Domestic Homicide Review Overview Report

'Kathleen'

Died: March 2019

Paul Johnston – Independent Domestic Homicide Review Chair and overview report Author

February 2023
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Contents

Dissemination

This full and final report will be published by the Middlesbrough Community Safety Partnership and will also be copied to those organisations mentioned below. The Individual Management Reviews, agency chronologies and other supporting documentation will not be published:

- *Middlesbrough Community Safety Partnership*
- *Teeswide Adult Safeguarding Board*
- Middlesbrough Domestic Abuse Strategic Partnership
- *South Tees Health and Well Being Board*
- Cleveland Office of Police Crime Commissioner

Preface

The Middlesbrough Community Safety Domestic Homicide Review Panel would like to express its profound condolences and sympathy to Kathleen's (not her real name) friends and family.

At all times the panel has tried to view what happened through Kathleen's eyes. The agencies involved would like to assure everyone that while undertaking this review, they have sought to learn lessons to improve the response of organisations to domestic abuse.

The independent Chair and Author of the review would like to express his appreciation for the time, commitment and valuable contributions of the review panel members and the agency report Authors.

1. INTRODUCTION

1.1 This is the overview report of a Domestic Homicide Review (DHR) following Kathleen's[1] manslaughter in March 2019. Kathleen's death met the criteria for conducting a Domestic Homicide Review under Section 9 (3)(a) of the Domestic Violence, Crime, and Victims Act 2004[2], in that her homicide was committed by her son Trevor (not his real name). The report is marked '*Official Sensitive*' under Government Security Classifications of 2018[3] and is an anthology of information and facts gathered from a multi-agency chronology, information supplied by agencies, from the two parallel reviews (see Section 7 below), from an interview with Trevor and from open-source material. The review was also supported by a retired Forensic Consultant Psychiatrist who has extensive experience in community psychiatry and managing the care of difficult to engage service users with psychosis.

1.2 In March 2019, Trevor went to his local police station and told officers that he had killed his mother[4]. He was arrested. He was later charged with Kathleen's murder and was remanded in custody to the mental health care wing of a prison and then later transferred to a forensic ward under Section 48/49 Mental Health Act 1983[5].

1.3 Trevor, a diagnosed paranoid schizophrenic, told the police that he had stabbed his mother after he had apologised to her for stabbing her in the neck and sucking her blood 18-years previously. He added that when she had refused to forgive him, voices in his head had told him to kill her and that she would then come back to life.

Comment: *The police have no record of the stabbing incident referred to by Trevor and due to the passage of time, it has not been possible to establish why. Medical records indicate that in May 2002, Kathleen attended a hospital with a superficial neck wound.*

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[1] The pseudonym 'Kathleen' was chosen by the review panel in keeping with the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016), which states that domestic homicide review overview reports and executive summaries should be anonymised.

[2] https://www.legislation.gov.uk/ukpga/2004/28/contents

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/715778/May-2018_Government-Security-Classifications-2.pdf

[4] *Trevor had repeatedly stabbed Kathleen with a kitchen knife.*

[5] https://www.legislation.gov.uk/ukpga/1983/20/section/48. Section 48 of the Mental Health Act is used when a person is on remand in prison, but their mental illness requires treatment in hospital. Section 48 can include a restriction order which is known as Section 49, making it a Section 48/49.

1.4 In July 2019, after denying murder but admitting manslaughter, Trevor was sentenced to a hospital order and a restriction order under the Mental Health Act, which prevents him from being released from the mental health facility unless directed by the Home Office or a Mental Health Tribunal. The court was told that Trevor had said that he had stopped taking his medication up to six-days before killing Kathleen and that doing so had likely caused a significant decline in his mental health. Trevor had told professionals that the day before he had killed his mother, he had 'killed himself' by jumping off a bridge on to a train and that he had then come back to life to kill her. He said he had expected his mother to reappear just as he had done. During the proceedings, the Judge said, "*... I cannot see [Trevor] being released from hospital for the foreseeable future...[Trevor] has had a long history of mental illness...There was violence to his mother, particularly when he was [age redacted], when he admitted to stabbing her and sucking her blood...His mother had a number of her own demons including drug and alcohol addiction, as did the defendant...In light of this he has committed few convictions, the last one was in 2004 when he served a short time in prison.*"

1.5 ## THE PURPOSE OF A DOMESTIC HOMICIDE REVIEW

1.6 The purpose of a Domestic Homicide Review[6] is to:

- *Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.*
- *Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.*
- *Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.*
- *Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.*

[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

- *Contribute to a better understanding of the nature of domestic violence and abuse.*

- *Highlight good practice.*

1.7 THE DECISION TO COMMISSION A DOMESTIC HOMICIDE REVIEW

1.8 In keeping with agreed protocol, in March 2019, the police notified the Middlesbrough Community Safety Partnership of the circumstances of Kathleen's manslaughter because she had been killed by someone to whom she was related. Agencies were asked to undertake a review of their records to identify any information they held about Kathleen and about Trevor; they were also asked to secure their records.

1.9 On 9th April 2019, at a meeting of relevant partners, it was determined that the circumstances of Kathleen's death met the criteria for a DHR. On 17th April 2019, the Chair of the Middlesbrough Community Safety Partnership notified the Home Office of the decision. At a preliminary DHR meeting, a representative of NHS England suggested the circumstances of Kathleen's death might also have met the criteria for an Independent Mental Health Review (MHR), so the Home Office was notified of the intention to integrate the two reviews under the auspices of the MHR. However, in September 2019, the Middlesbrough Community Safety Partnership was told by NHS England that the criteria had not in fact been met for an MHR. The Partnership therefore appointed an independent DHR Chair and report Author. NHS England offered to commission the independent mental health expert mentioned at paragraph 1.1, which was accepted. The first full DHR meeting took place in council offices on 20th January 2020, but all subsequent panel meetings have since taken place via video conferencing platforms because of restrictions and factors associated with the Coronavirus pandemic.

2. CONFIDENTIALITY

2.1 In line with the statutory guidance, a bespoke panel was formed to conduct the review. In the interests of transparency, all members of the review panel are named in paragraph 6.1 of this report and their respective roles and the agencies they represent are set out. The review panel all signed-up to the following principles of confidentiality during the review process:

- *Information discussed by any agency representative within the ambit of a panel meeting (whether virtual or in person) would be strictly confidential and treated as such during the meeting and in the subsequent handling of any data considered at it*

- *The information was not to be disclosed to third parties without the prior agreement of the partners of the meeting.*

- *Information shared should be directly or indirectly relevant to the review*

- *Clear distinctions should be made between fact and opinion*

- *All agencies were to ensure that if any minutes of meetings were recorded, they would be retained in a confidential and appropriately restricted manner. Any minutes would aim to reflect that all individuals who are discussed during the meetings would be treated fairly, with respect and without improper discrimination. All work undertaken would be informed by a commitment to equal opportunities and effective practice issues in relation to age, disability, gender, gender identity, race, religion, and sexuality.*

3. TIMEFRAME AND TERMS OF REFERENCE FOR THE REVIEW

3.1 After careful consideration, it was agreed to review each agency's involvement with Kathleen and with Trevor between 1st January 2015[7] and the date of Kathleen's manslaughter in March 2019, subject to any information emerging that prompted a review of any earlier incidents or events that were relevant. The review panel also examined the mental health care received by Trevor dating back to 1st January 2001.

3.2 In addition, agencies were asked to provide a summary of any involvement they may have had with Kathleen and Trevor prior to the review timeframe (and any relevant information that may have come to light after Kathleen's death).

3.3 The Terms of Reference for the review were set to determine:

- *Whether the incident in which Kathleen died was an isolated event and whether there were any warning signs*

- *What knowledge each agency had that indicated Trevor might be a perpetrator of domestic abuse towards his mother*

- *Whether local agencies should have known more about the history of abuse between Trevor and Kathleen.*

[7] January 2015 was chosen because Kathleen had moved to the Middlesbrough area by that time and the panel felt it would enable learning to be identified from multi- agency working in contemporary systems as opposed to historical services and systems that had since changed.

- *Whether there were any barriers experienced by Kathleen or family/friends/colleagues in reporting any abuse in Middlesbrough or elsewhere, including whether they knew how to report domestic abuse should they have wanted to*

- *What safeguarding concerns in respect of Kathleen were considered throughout Trevor's contact with services*

- *Whether, when Trevor was formally reviewed by community team members, there was evidence that they specifically explored or enquired about the issues of his unusual ideas about death/reincarnation, about possessing special powers, and about unusual ideas regarding his mother*

- *When and how often did Kathleen contact the team to raise concerns about Trevor*

- *Whether the most recent risk assessment included a complete list of Trevor's criminal offences and other assaultive behaviours*

- *If there were issues in relation to capacity or resources for agencies that impacted on their ability to provide services to Kathleen or Trevor, or their ability to work effectively with other agencies*

- *Whether the learning in this review appear in other domestic homicide reviews commissioned by Middlesbrough Community Safety Partnership*

4. METHODOLOGY

4.1 To understand what services might have looked like to Kathleen and to Trevor, the review sought, (without success), to involve those around them including their family, friends, and neighbours and those in the community, as well as professionals (see later).

4.2 Upon notification of Kathleen's suspected murder, a multi-agency scoping exercise was undertaken to determine whether agencies had any involvement with Kathleen or with Trevor in any context relevant to the review. (Enquires were made with both Redcar and Cleveland and Middlesbrough substance misuse services, but there was nothing on their systems about them). The following agencies confirmed they held information:

- Tees, Esk and Wear Valleys NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust
- Cleveland Police

- NHS South Tees Clinical Commissioning Group (changed to NHS Tees Valley Clinical Commissioning Group in April 2020) for both Kathleen's and Trevor's GP Practices
- Thirteen Housing Group Limited
- Harbour Support Service

4.3 Agencies that had been involved with Kathleen and with Trevor were asked to produce Individual Management Reviews (IMRs)[8]. They were asked to include a comprehensive chronology of their involvement, a summary of what happened, details of any intelligence and information known to the agency, what decisions were reached, what services were offered and provided and any other action that may have been taken. Further, the IMRs were to be completed with the review 'Terms of Reference' in mind and were to consider not only whether procedures had been followed, but whether, on reflection, they had been adequate.

4.4 The IMRs produced during this review were of a high standard albeit some were received out of time (this was largely due to pressures associated with the pandemic). They were quality assured by the respective agency and by the panel Chair and where challenges were made, they were responded to promptly and in a spirit of openness and co-operation. The review panel members and the IMR Authors have been committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, and collectively they have ensured the review has been carried out with integrity.

4.5 The Chair's extensive knowledge of previous domestic homicide reviews and of aspects of domestic abuse has been utilized during this review as has the wealth of professional knowledge of the review panel members. The review was supported by Dr John McKenna who has extensive experience in community psychiatry and managing the care of difficult to engage service users with psychosis. Dr McKenna also undertook a desk-top review of the internal investigation undertaken by Tees Esk and Wear Valley NHS Foundation Trust to ensure that key lines of enquiry were explored and to highlight areas requiring further examination.

4.6 The Middlesbrough Domestic Homicide Scrutiny Panel will monitor the implementation of the action plans that have emanated from this review on behalf of the Middlesbrough Community Safety Partnership who will remain accountable for the implementation of the learning

[8] The aim of an IMR is to look openly and critically at individual and organisation processes and practices and to provide an analysis of the service they provided. The IMR authors were independent in that they had no previous involvement with Kathleen or with Trevor or any line-management responsibility for staff that had been involved with them.

from it. A copy of the final report and updates regarding progress in relation to actions will also be shared periodically with the Middlesbrough Domestic Abuse Partnership and the Tees-wide Adult Safeguarding Board.

4.7 The panel determined that any media interest in relation to the review would be managed by the DHR Chair in consultation with the Middlesbrough Domestic Abuse lead and the council's Press Officer.

4.8 The review panel took account of coronial and criminal proceedings in terms of timing and attempting to contact Kathleen's family, friends, and Trevor, to ensure that relevant information could be shared without incurring significant delay in the review process or risk of compromise to the judicial process.

5. INVOLVEMENT IN THE REVIEW

5.1 There was no family involvement in the review. Other than Trevor, Kathleen had only two living relatives. Her sister did not wish to be involved in the police investigation into Kathleen's death and she did not reply to a letter of invitation to participate in this review (the letter was accompanied by the Home Office information leaflet for family members of domestic abuse homicide victims). A similar letter to an aunt was returned 'Not known at the address' and the police have been unable to identify an alternative address for her. She too had declined to be involved in the police investigation into Kathleen's death.

5.2 INVITATION TO TREVOR TO PARTICIPATE IN THE REVIEW

5.3 Trevor was interviewed[9] by the review Chair within a secure mental health establishment in November 2022 in the presence of his Specialist Clinical Psychologist. The review panel recognised that Trevor is still mentally unwell, but with his consent and with the agreement of the mental health professionals who are caring for him, it was considered worthwhile exploring whether he might be able provide information to enrich the quality and depth of the review. The panel had been mindful that there was very little agency information about Kathleen and her life and that there was no involvement of family and friends in the review. Much of what Trevor said did not enhance the review, but where he was able to provide some useful insight, comment has been made about it in this report.

[9] No-one can be compelled to participate in a DHR process. When an interview with a perpetrator does take place, it is not always possible to challenge what they say and sometimes explanations they provide can be inconsistent with other known aspects of a case.

5.4 FRIENDS, NEIGHBOURS AND THE WIDER COMMUNITY

5.5 A friend who went to the police station with Trevor after he had killed Kathleen did not respond to an invitation to participate in this review and no information was forthcoming to indicate that neighbours or anyone else in the wider community were able to assist the review.

6. THE REVIEW PANEL

6.1 The review panel consisted of the following, all of whom were independent in that they had not previously been involved with Kathleen or with Trevor or had line management responsibility for anyone who had.

Comment: *As mentioned previously, most review panel meetings were held via a video conferencing platform because of Covid-19. The expected levels of participation and analysis by panel members was not adversely affected by this and the review Chair is satisfied that issues raised during the review were addressed fully and from several perspectives and disciplines.*

Paul Johnston	Chair and report Author	Review and Investigation Ltd
John McKenna	Retired Forensic Consultant Psychiatrist	
Claire Moore	Domestic Abuse and Sexual Violence Lead	Middlesbrough Council
Lisa McGovern	Service manager	My Sisters Place
Alistair Russell	Lead Officer	Middlesbrough Council
Helen Smithies	Assistant Director of Nursing (Safeguarding)	South Tees Hospitals NHS Foundation Trust
Karen Agar	Associate Director of Nursing (Safeguarding)	Tees Esk and Wear Valleys NHS Foundation Trust
Gordon Bentley	Senior Adult Safeguarding Officer	NHS Tees Valley Clinical Commissioning Group
Alison Peevor	Head of Quality and Safeguarding	NHS Tees Valley Clinical Commissioning Group
Patricia Fenby	Detective Inspector	Cleveland Police
Janice McNay	Head of governance and compliance	Thirteen Housing Group Limited
Danielle Chadwick	Service manager	Harbour Support Services

Mandy Cockfield	Interim Principal Social Worker	Redcar and Cleveland Council
Rachel Burns	Advance Public Health Practitioner - Substance Misuse	South Tees Public Health
Gemma Swan	Operations Manager	Substance Misuse Service Middlesbrough Council

6.2 REVIEW CHAIR AND AUTHOR OF THE OVERVIEW REPORT

6.3 The Middlesbrough Community Safety Partnership appointed Paul Johnston to undertake the roles of Independent Chair and overview report Author for the review. He is an independent practitioner who has chaired and written numerous domestic homicide reviews, child serious case reviews, adult safeguarding reviews, and multi-agency public protection arrangement (MAPPA) serious case reviews. He has never worked for any agency in the Middlesborough area. He has a wealth of safeguarding and multi-agency working experience and has enhanced knowledge of domestic violence and abuse issues including so-called 'honour-based' violence, research, guidance, and legislation relating to adults and children. He is also a former chair of MAPPA. He has completed all the Home Office approved domestic homicide review training and he also delivers his own independent domestic abuse and homicide review training. He was judged to have the necessary independence, experience, and skills for the task.

6.4 Dr John McKenna was the deputy medical director at Lancashire Care NHS Foundation Trust and has extensive experience in risk assessment, forensic mental health services and prison mental health. His recent clinical work has been almost exclusively in the community, leading the local forensic community service. He was able to support the review through his expertise in community psychiatry and managing the care of difficult to engage service users with psychosis.

7. PARALLEL PROCESSES

7.1 There was a police investigation into the circumstances surrounding Kathleen's death, with Trevor subsequently being charged with her murder. In July 2019, after denying murder but pleading guilty to manslaughter, he was sentenced to a hospital order and a restriction order under the Mental Health Act.

7.2 Kathleen's death was referred to the coroner who opened an inquest and then adjourned it because Trevor had been charged with her murder. It is a Coroner's prerogative to resume an inquest following a criminal trial, but where an inquest does resume, its outcome (conclusion or determination) as to the cause of death, must not be

inconsistent with the outcome of the criminal proceedings. To date, the coroner has not intimated any intention to resume the inquest into Kathleen's death.

7.3 The Tees, Esk and Wear Valleys NHS Foundation Trust conducted a Serious Incident Investigation and NHS England commissioned an independent review of the Trust's Serious Incident Investigation.

Comment: *The DHR Chair has liaised with the Authors of both investigation reports.*

8. EQUALITY, DIVERSITY, AND INCLUSIVITY

8.1 Section 4 of the Equality Act 2010[10] sets out nine protected characteristics. Discrimination which happens because of one or more of these characteristics is unlawful under the Act:

- *Age*
- *Disability*
- *Gender reassignment*
- *Marriage and civil partnership*
- *Pregnancy and maternity*
- *Race*
- *Religion or belief*
- *Sex*
- *Sexual orientation.*

Section 6 of the Act states:

A person (P) has a disability if:

- P has a physical or mental impairment, and
- The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

8.2 The Act offers protection from discrimination for every individual. Importantly, the Act prohibits any protected status for domestic abuse and violence. The review gave due consideration to each of the nine protected characteristics under Section 149 of the Equality Act 201012, as well as to wider matters of vulnerability for both the victim and the alleged perpetrator.

8.3 Kathleen was 55 years old when she was killed, and she was white British. Trevor was 34 years old when he killed his mother, and he is also white British. English was their language of communication. They were living close to one another in an area which is predominantly of the

[10] https://www.legislation.gov.uk/ukpga/2010/15/section/4

same culture as them. There is no evidence to suggest that Kathleen and Trevor being white British citizens were ever an issue in the manner in which agencies delivered services to them. No information came to light during the review to identify whether Kathleen or Trevor followed any faith or and there was no information revealed in the review to show that religion had an influence on the relationship. There was no indication that either had a sexual orientation other than heterosexual nor that either was of a sex they were not ascribed to at birth. The panel was satisfied that services provided were generally appropriate but felt that gender, in relation to matricide and specific vulnerabilities in relation to mental health and substance misuse were of particular relevance.

8.4 Gender: The Panel, when considering Kathleen's vulnerability as a woman, considered if violence against women required specific consideration. Domestic abuse and domestic homicide are considered to be, most often, gendered crimes (Stark, 2007). The latest Office for National Statistics figures (2022/23)[11] show that one in three victims of domestic abuse are male equating to 751,000 men (3.2%) and 1.38 million women (5.7%). From this, 483,000 men and 964,000 women are victims of partner abuse. The significance of gender and violence against women is particularly relevant when we consider this homicide was matricide. Matricide is a gendered form of violence, given that women are disproportionately represented as victims compared to other forms of violence (aside from domestic homicide by current or ex partners) and son-mother killings are a form of femicide. The number of women killed by sons has shown a steady and alarming rise since 2016. In the census's 10-year report (2009-2018)[12] 109 (8%) of the total of 1,435 women killed by men were mothers killed by sons while 11 grandmothers were killed by grandsons over the decade. In the latest femicide statistics in 2020 the figure for matricide was 5% - which equated to 14 killings of mothers and grandmothers in a single year. In Middlesbrough of the seven domestic homicide reviews initiated since 2016 two of those have involved matricide

Intersectional invisibility of mother-victims The Review applied an intersectional framework[13] in order to understand the lived experiences of both victim and perpetrator. The DHR panel identified that Kathleen as a mother and carer was frequently not 'seen' by the services treating Trevor and by the professionals they interacted with. The role

[11] ttps://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusepre valenceandtrendsenglandandwales/yearendingmarch2023

[12] https://www.femicidecensus.org/

[13] Intersectional Framework means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand an individual's journey and experience with local services and within their communities.

she played in Trevor's life was not considered and her needs were not always considered. The panel recognised complete lack of information about the family and the relationship between the perpetrator and his mother in service records and acknowledged that services had made no effort to contact her. Kathleen, as a mother of a son experiencing mental ill health and with her own physical and mental health conditions was relegated her 'to a position of acute social invisibility' (Purdie-Vaughns and Eibach, 2008[14]).
The Homicide Abuse Learning Together (HALT) at Manchester[15] Metropolitan University analysed the findings and processes of 302 Domestic Homicide Reviews (DHRs) as part of a research project - funded by the Economic and Social Science Research Council (ESRC) In a study of 66 DHRs that included 26 mothers killed by their sons, interlinked precursors to child to parent killing were detected – mental ill health, substance/alcohol abuse, criminal history, childhood trauma, financial factors and care. Again, as identified within this DHR the mothers were not always considered by those supporting the perpetrator.

8.5 Mental health and substance use were also considered in the review as vulnerabilities for both the victim and alleged perpetrator. The panel has been mindful of the need to consider and reflect upon the impact, or not, of the vulnerabilities and if this played any part in how services responded to their needs. There was no evidence arising from the review of any bias in relation to vulnerabilities below.
Mental Health: Trevor's extensive psychiatric history is described in detail throughout this report. Trevor was first diagnosed with paranoid schizophrenia in July 2004 which was consistently and exclusively also made throughout the following nearly fifteen years. Kathleen had accessed GP Surgery and requested counselling for low mood on more than one occasion which she was encouraged to self-refer to talking therapies. Although Kathleen had a history of mental ill-health, no agency had a record of there ever being a need to assess Kathleen in relation to this.
Substance Misuse Although there are references in this report to the use of alcohol and illicit drugs by Kathleen and by Trevor, the Equality Act specifically provides that addiction to alcohol, nicotine, or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Act.

[14] Intersectional Invisibility: The Distinctive Advantages and Disadvantages of Multiple Subordinate-Group Identities | Sex Roles (springer.com)
[15] https://domestichomicide-halt.co.uk/about/

Although there are references in this report to the use of alcohol and illicit drugs by Kathleen and by Trevor, the Equality Act specifically provides that addiction to alcohol, nicotine, or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Act.

9. STRATEGIC GOVERNANCE AND DEFINITIONS

9.1 The domestic abuse and sexual violence lead in Middlesbrough[16] has responsibility for coordinating all DHRs and ensuring reports and action plans meet required standards. All approved DHR action plans are uploaded to the Councils' risk management system where they are monitored. Partnership organisations can update progress in relation to single agency and partnership recommendations. The actions and evidence in relation to those are reviewed by a DHR scrutiny panel. DHR updates are included as standard agenda items at both the Middlesbrough Community Safety Partnership and Middlesbrough Domestic Abuse Strategic Partnership on a quarterly basis. Regular updates are provided to the Tees-wide Safeguarding Adults Board so that learning and recommendations can be shared across Cleveland.

9.2 ### DOMESTIC VIOLENCE AND ABUSE DEFINITION

9.3 Under the Domestic Abuse Act 2021, the new legal definition of domestic abuse[17] is defined as any incident or pattern of incidents of physical or sexual abuse, violent or threatening behaviour, controlling or coercive behaviour, economic abuse, psychological, emotional, or other abuse between those aged 16 and over and personally connected to each other.

9.4 Domestic abuse is present in all types of relationships including lesbian, gay, bisexual, and transgender and it can also involve other family members, including children. Domestic abuse can happen to anyone, it can occur regardless of age, gender, race, sexuality, economic position, and geography. Women are more likely to experience repeat victimization, be physically injured or killed as result of domestic abuse and experience non-physical abuse (including emotional and financial abuse), than men.[18] By far most domestic abuse perpetrators are male. A detailed breakdown of homicides reveals substantial

[16] A summary of domestic abuse services available in Middlesbrough can be found at https://www.middlesbrough.gov.uk/crime-and-safety/domestic-abuse
[17] https://www.legislation.gov.uk/ukpga/2021/17/section/1/enacted

[18] Domestic Abuse: Findings from The Crime Survey for England and Wales - Office for National Statistics
https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2022

gendered differences. Over three-quarters (77%) of female domestic homicide victims are killed by a partner/ex-partner, with the remaining 23% killed by a family member. For male homicides, there is a more even split, with around a half (51%) of victims killed by a partner/ex-partner and the other half (49%) killed by a family member. The fact that Kathleen was killed by her son makes the circumstances of this case relatively unusual.

9.5 A report has recently been published which analysed DHRs from October 2019 to September 2020[19]. The DHR panel reflected that the circumstances of this case also reflected themes identified in that report. Of the 124 DHRs across England and Wales in that period, 127 victims were identified. The perpetrator was the victim's partner in 73% of those cases whereas there was a family relationship between the victim and the perpetrator in 27% of the cases. In 20% of the DHRs the victim was 20 (or more) years older than the perpetrator, with the perpetrator being the son of the victim in 56% of the reviews. Sixty one percent of the victims had a vulnerability, with 27% having more than one. Of the vulnerabilities, 34% were mental ill-health, 28% were problem alcohol use and 22% were illicit drug use. Twenty-six percent of those with a mental health vulnerability were recorded as having depression and 14% also identified as having low mood/anxiety. Seventy one percent of perpetrators were considered to have vulnerability with 31% affected by mental health issues. Sixty-two perpetrators were sentenced for murder, 25 for manslaughter and 13 were deemed to have diminished responsibility or to be unfit to plead.

9.6 ## COERCIVE AND CONTROLLING BEHAVIOUR

9.7 Controlling behaviour includes a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour includes an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten a victim.

9.8 Where there is a personal connection between two parties, controlling or coercive behaviour is a criminal offence.[20] It can take many forms

[19] https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/quantitative-analysis-of-domestic-homicide-reviews-october-2020-september-2021-accessible
[20] Section 76 of the Serious Crime Act 2015.

but often involves a pattern of continued and repeated abuse. Coercive control is usually personalised, in that it means something to the victim even when the meaning is not apparent to anyone else. The abuse may appear routine or 'low-level' to the outside observer therefore, but its hidden significance to the victim will often cause anxiety and fear. It can also create an environment in which increasingly harmful conduct is accepted as normal by the victim. Abusers can be imaginative in the ways in which they control, abuse, or humiliate their victims and in the consequences that may result from disobeying.

9.9 Examples of controlling or coercive behaviour include, but are not limited to:

- *Constant criticism*
- *Humiliation*
- *Jealous or possessive behaviour, for example, making frequent telephone calls to check where the victim is and what they are doing or checking activity on the victim's telephone or e-mail address*
- *Threats of suicide/homicide/familicide*
- *Threats or actual self-harm*
- *Threats of harm to pets*
- *Controlling family finances, withholding, or restricting the victim's access to money*
- *Isolating the victim by not allowing them to visit friends and family or for family and friends to visit them*
- *Restricting a victim's movements, for example, confining them to a room, being made to account for their time*
- *Dictating what a victim wears or how they do their hair*
- *Dictating a victim's routine or schedule, for example timing of shopping trips*
- *Intercepting communications, for example, letters, messages, or telephone calls.*

9.10 ABUSE OF PARENTS BY THEIR CHILDREN

9.11 Child-to-parent abuse is one of the most under-reported and under-researched subject areas in the field of domestic abuse. What research there is tends to focus upon adolescent aggression, but Trevor was in his mid-30s when he killed his mother, although he had been extremely violent towards her when he was in his teens.

9.12 A Home Office information guide on adolescent to parent violence and abuse (APVA)[21] states at paragraph 1.4, *'It is important to*

[21] https://safelives.org.uk/sites/default/files/resources/HO%20Information%20APVA.pdf

recognise that APVA is likely to involve a pattern of behaviour. This can include physical violence from an adolescent towards a parent and a number of different types of abusive behaviours, including damage to property, emotional abuse, and economic/financial abuse. Violence and abuse can occur together or separately. Abusive behaviours can encompass, but are not limited to, humiliating language and threats, belittling a parent, damage to property and stealing from a parent and heightened sexualised behaviours. Patterns of coercive control are often seen in cases of APVA, but some families might experience episodes of explosive physical violence from their adolescent with fewer controlling, abusive behaviours. Although practitioners may be required to respond to a single incident of APVA, it is important to gain an understanding of the pattern of behaviour behind an incident and the history of the relationship between the young person and the parent'.

9.13 A Standing Together Report[22] in relation to Adult Family Violence (AFV) showed that this is gendered in relation to victimisation and perpetration, albeit with a more pronounced gender split in the latter. Between April 2014 and March 2017, the Home Office Domestic Homicide Index recorded 400 domestic homicides, of which 114 were adult family homicides (28% of all domestic homicides) (Office for National Statistics, 2018). Ninety percent of perpetrators of adult family homicides were men, with mothers and sisters being the victims of fatal violence from their sons and brothers. As in this DHR, mental health issues were the most common feature of the majority of perpetrators of AFV, including depression, self-harm, psychosis and paranoid schizophrenia with many of perpetrators also being identified as misusing substances.

9.14 The Standing Together report in relation to AFV also identified that in many cases due to complex family relationships, caring responsibilities, and perceived support needs of the perpetrators, as well as lack of suitable options, family members affected by abusive behaviours are often less likely to engage with the police, prosecution, or an Independent Domestic Violence Advisor (IDVA)[23]. They are more likely to minimise their safety concerns and be less able to formally articulate their experience as 'abuse'. This could in turn reinforce assumptions made by key professionals, such as police and the Crown Prosecution Service, about their level of risk, thereby increasing victims' isolation and barriers to their help-seeking and access to support. The panel

[22] https://www.standingtogether.org.uk/blog-3/adult-family-violence-briefing

[23] *An IDVA works with both men and women who are 'High-risk' victims of domestic abuse. The IDVA's are specially trained to provide unbiased advice and information and to work in partnership with other agencies to increase safety for individuals experiencing domestic abuse. Their aim is to reduce the risks of further incidents by carrying out risk-assessments and safety planning. They provide signposting and access to other services, such as health, substance misuse and mental health.*

feel this and social isolation of both the victim and the perpetrator were relevant dynamics and risk factors in this DHR.

9.15 Extensive other research[24] by the DHR Chair during this and other reviews led him to conclude there are three main contributors to child-to-parent abuse; mental ill-health, attachment factors (possibly related to a mental health issue) and/or previous experiences of abuse, although frequently held assumptions that a child is abusive because they have themselves suffered some forms of abuse were not true in many cases.

9.16 A particular issue for agencies is that the abuse tends to remain hidden from public view. The review panel speculated that being abused by their own offspring is likely to be considered by many parents to be a taboo subject and as is the case in some other forms of abuse, the victim may well feel ashamed or humiliated or think they should be able to handle the situation without outside help. In addition, some parents may feel it is not safe for them to attempt to control the situation for fear of inflaming it.

10. BACKGROUND INFORMATION ABOUT KATHLEEN AND TREVOR

10.1 ### KATHLEEN

10.2 According to Trevor, Kathleen worked as a care home assistant until he was born and since then she had been unemployed. Trevor said he could not remember a time when his mother was not a heavy user of alcohol and illicit drugs and that for many years, she had the same partner who was alcohol dependent. Trevor said he did not think domestic abuse was a feature of the relationship between his mother and her partner, but that their mutual alcohol abuse would often cause considerable friction between them.

10.3 Trevor added that his mother and her partner split-up in 2014 and that after that she did not have another intimate partner. He said his mother was never married. He also said his mother was addicted to painkillers and that she would source them from friends and that occasionally he would buy some for her from local pharmacies. Trevor said his mother suffered from depression at times which he thought was associated with her inability to manage her financial affairs, adding that she spent a large part of her income on alcohol and drugs.

[24] Coogan, D. (2017) Child to Parent Violence and Abuse, Family Interventions with Non-Violent Resistance and Holt, A. (2017) Parricide in England and Wales (1977-2012): An exploration of offenders, victims, incidents and outcomes, Criminology and Criminal Justice et al.

10.4 TREVOR

10.5 Trevor is single. He had no contact with his father after his parents separated during his early childhood after which he and his mother moved to a nearby small town. He did not attend school from that point, attained no qualifications and remained long-term unemployed. Trevor began using alcohol and by the age of 17 he was also using heroin and cocaine.

10.6 Between 2000 and 2004, he was convicted on eight occasions of offences ranging from assault to theft. He told professionals that he first had odd beliefs and ideas when he was 16 and that he had twice tried to kill himself. He added that he had stabbed his mother in her neck and had then sucked her blood sometime in 2002 (more is said of this below) and that he had hit his mother's partner with a hammer. It was recorded that he had asked his mother's partner to hit him 'For all the wrongs he had done' and when the partner refused, Trevor attacked him. (Trevor was later convicted of assaulting his mother's partner with the hammer).

Comment: *Nowadays, such incidents would undoubtedly be referred to a Multi-agency Risk Assessment Conference (MARAC)*[25].

10.7 In 2004, Trevor was sent to a Young Offenders Institute having been convicted of burglary. Whilst there, he was cautioned for an attempted sexual assault on a female psychiatrist. Records suggest he admitted stabbing two horses, (setting fire to one of them), and that he had killed a lamb (the Crown Prosecution Service decided not to proceed with prosecutions in respect of animal cruelty and arson). It was documented that when he was unwell there was a significant risk of violence towards others and himself and that he could become sexually disinhibited.

10.8 In January 2005, Trevor was assessed as posing a 'high-risk' of causing serious harm to others and he was referred to Multi-agency Public Protection Arrangements (MAPPA)[26]. He was re-graded to 'medium risk' in 2007. In 2009 the MAPPA screening panel determined he did not

[25] tps://www.gov.uk/government/publications/multi-agency-risk-assessment-conference-marac-protection-plans-requests-for-evidence. Established in Wales in 2003, MARACs did not become fully operational in other parts of the UK until 2006 as a component of the Home Office's National Domestic Violence Delivery Plan. A MARAC is a meeting where information is shared on the highest-risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advocates, probation, and other specialists from the statutory and voluntary sectors. The primary focus of the MARAC is to safeguard the victim and manage the behaviour of the perpetrator. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety.

[26] The Criminal Justice Act 2003 established Multi-Agency Public Protection Arrangements (MAPPA). Details of the process and case levels can be found at Appendix A to this report.

meet the criteria for levels 2 or 3 MAPPA and that he could be managed by a single agency and recommended that he be managed via the Care Programme Approach (CPA)[27].

10.9 After Trevor had expressed bizarre and sometimes violent ideas, some of which directly related to his mother, he was again reviewed by forensic services in late 2006. From September 2006 to August 2009, Trevor was for the first time detained under Section 3 Mental Health Act 1983 (MHA)[28]. He spent time on a psychiatric intensive care unit and was then moved to an open general ward.

10.10 In January 2008, Trevor was transferred to medium secure conditions (where he was first prescribed the antipsychotic drug Clozapine[29]), and then in April to a forensic rehabilitation ward.

10.11 In August 2009, Trevor began a period of community care that lasted over nine years, up to him killing Kathleen (August 2009 to March 2019). Initially, medical oversight and care co-ordination was provided by a local Assertive Outreach Team[30], with additional input provided by the Forensic Adult Outreach Service (FOLS)[31].

10.12 In September 2010, Trevor was discharged from forensic services to be managed solely by the local Community Mental Health Team (CMHT). His GP was advised that his illness was treatment-resistant and that if he became non-concordant with medication and used illicit substances, he would pose a significant risk to others. He was rated as Cluster 17 (Psychosis and Affective Disorder; difficult to engage)[32]

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[27] The Care Programme Approach is a package of care for people with mental health problems. See https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

[28] https://www.legislation.gov.uk/ukpga/1983/20/section/3 Section 3 MHA allows for a person to be admitted to hospital for treatment if their mental disorder is of a nature and/or degree that requires treatment in hospital. In addition, it must be necessary for their health, their safety or for the protection of other people that they receive treatment in hospital.

[29] Clozapine is an antipsychotic used in the treatment of schizophrenia when other antipsychotics have not worked. Clozapine is a drug which must only be prescribed by secondary care mental health services and prescribing responsibility will not transfer to GPs under any circumstances. Since Clozapine can cause neutropenia and agranulocytosis regular blood tests are required. Since Clozapine can cause serious health complications, regular blood tests are required. This entails differential white blood cell monitoring weekly for 18-weeks, then fortnightly for up to one year, and then monthly as part of the Clozapine patient monitoring service (Clozapine clinic).

[30] Assertive Outreach Teams are part of secondary mental health services and are usually attached to the Community Mental Health Team. They work with people who are 18 to 65 who have particularly complex needs and need more intensive support to work with services.

[31] FOLS provide enhanced care and treatment in a community setting to keep individuals out of secure hospital and prison, by working to reduce their risk of encountering the Criminal Justice System in the first place.

[32] https://www.england.nhs.uk/wp-content/uploads/2021/03/21-22NT_Annex-DtD-Technical-guidance-for-mental-health-clusters.pdfA cluster is a global description of a group of people with similar characteristics as identified from a holistic assessment and then rated using the Mental Health

10.13 From 2013 onwards Trevor's mental health and his general and social functioning improved. In early 2014, he was allocated to Cluster 12 ('ongoing recurrent psychosis, high disability'). His care plan specified that 'Ongoing monitoring and treatment is required to ensure his sustained recovery, minimise his risk profile'.

10.14 A 'FACE'[33] Risk Assessment completed in January 2014 stated that people who were potentially at risk from Trevor included 'Staff, public and parent'. It was recorded that he said he was not using illicit substances and was rarely drinking alcohol and that he was very proud of his achievements in respect of his drug and alcohol use.

Comment: *Trevor told the review Chair that around 2014/15, he started drinking alcohol for the first time since 2009. He said he would restrict it to a few cans of lager or cider every other day and that he never tried to hide his drinking from medical professionals. He added that he did not start taking illicit substances again until 2017.*

10.15 ## SUMMARY OF DR MCKENNA'S FINDINGS

10.16 Below is a summary of some of Dr Mckenna's findings from his review of the mental health care and treatment afforded to Trevor.

10.17 ### Trevor's diagnosis of paranoid schizophrenia

Trevor was first diagnosed with paranoid schizophrenia in July 2004 which was consistently and exclusively also made throughout the following nearly fifteen years. There was no evidence incompatible with that diagnosis.

10.18 ### Kathleen's potential vulnerability

The potential historical indicators (dating back to the early 2000s) of vulnerability on the Kathleen's part fell into three broad groups:

- General vulnerability (longstanding substance misuse and being a victim of domestic abuse by an intimate partner)
- Vulnerability relating to Trevor (the previous assaults)

Clustering Tool. Cluster 17 is a group that has moderate to severe psychotic symptoms with unstable, chaotic lifestyles. There may be some problems with drugs or alcohol. This group have a history of non-concordance, are vulnerable and engage poorly with services.

[33] Functional Analysis of Care Environments (FACE) is a risk assessment tool. About FACE: the applications of a structured approach to mental health information, R Elzinga, F Meredith - Australian Health Review, 2001 - CSIRO

- Trevor's bizarre thoughts about assaulting his mother and delusional beliefs regarding reincarnation and attaining special powers. (During the period 2006 to 2007, it was noted that Kathleen featured in many of Trevor's delusions, such as that killing her would be followed by her rebirth and him obtaining special powers, and that he blamed her for (what he considered) to be his facial deformity.

10.19 In early 2008 it was recorded that a doctor and social worker had arranged to visit Kathleen and that they would 'Ask about violence and communicate to her that he poses or may pose a risk to her in the future when in the community ... given the risk he poses, there is a view within the care team that such a disclosure is appropriate'. There is no record of whether the meeting ever took place, and the issue was not documented again.

10.20 Towards the end of Trevor's hospital stay, the records suggest he had increasing unproblematic and positive contact with his mother. This continued to be the case in the community from 2009 onwards, and there was nothing to indicate he posed a risk of violence to her as long as his mental health remained stable.

10.21 In late 2010, it was recorded that Trevor was willing to consider his mother being offered a carer's assessment (he later declined to involve her in his care planning), and a care coordinator recorded the intention to 'determine what actual relationship dynamics are present' [between Trevor and his mother]. There is no evidence of that happening. From 2012, Kathleen was not mentioned in Trevor's care plan records other than as his 'nearest relative'.

10.22 There was no record of any contact between Community Mental Health Trust staff and Kathleen between 2009 and 2019 and there was no record of whether the issue of contact with Kathleen was discussed with Trevor nor any record of discussion within the team about Kathleen's potential vulnerability.

Comment: *Trevor told the review Chair that for all intents and purposes, his mother ended up living with him almost full-time and in effect he became her carer. He added that she wouldn't live in her own flat because she couldn't pay the bills because she spent all her money on drugs and alcohol.*

10.23 ## Internal working between Trust Teams and services

Internal working and communication between Trust teams and services was of good quality.

10.24 ## Care Programme Approach (CPA) and Clozapine clinic

During the entire period of community supervision up until Kathleen's death, there was no evidence of instability in Trevor's mental state, including psychotic symptoms, or any known problems with his medication concordance. The assessment that Trevor posed a low level of risk was the correct one. Risk assessment documents were regularly updated and the 'triggers' identified were substance misuse, disengagement from services and medication non-concordance.

10.25 Trevor reliably attended monthly Clozapine clinics, the last being nine-days before he killed Kathleen. No untoward changes in his mental health were noted at any of them.

10.26 Dr Mckenna noted that a Trust document entitled 'Standard Process Description: Clozapine one stop clinic and supply of medication', included the phrases 'Assess service user mental state and presentation' and 'During the appointment the clinician will have a discussion with the patient about their mental state ...' Dr McKenna was told that Trevor was being seen four-weekly at the Clozapine clinic and that if there had been any concerns raised during the appointments, the clinic staff would have alerted the lead professional immediately who would then have taken the necessary steps to review Trevor. The inference from the Trust was that clinical assessment was undertaken at the Clozapine clinic, and that it amounted to a clinically relevant safety net, for example for picking up signs of relapse. However, Dr Mckenna was also told by the Trust's Patient Safety Team that the Trust Pharmacy Department had stated, 'Please note that the "Clozapine clinics" are not the setting where the patient's mental state is assessed, that would be done in separate outpatient review appointments with the clinical team ... The clinics are generally run by staff who aren't qualified to assess the patient's mental state. There is a basic assessment of physical health and side-effects, and a check of concordance with taking the Clozapine ... but that's as far as it goes'. Dr McKenna recommended that *'The Trust must revise internal policies and procedures relating to the functioning of 'Clozapine clinics' in order to be satisfied that any function relating to formal assessment of attendees' mental health status is clearly described and supported'*. The DHR panel consider this to be an important issue and have therefore included a recommendation from this review that assurance be provided by the Trust that the necessary action has been taken to address it.

10.27 Dr McKenna also noted that the Trust had already identified the need to conduct an audit to ensure there is no evidence of *'copy and pasting'* of entries in clinical records by Clozapine clinic staff, and it is felt appropriate for this review to seek assurances that the audit has been carried out and that subsequent action (if identified) has been actioned.

11. AGENCY CONTACT WITH KATHLEEN AND TREVOR - SIGNIFICANT EVENTS FROM 2015 ONWARDS

11.1 ### 2015

11.2 In January 2015, Trevor moved to an independent flat which was not far from his mother's new address. It was documented in his mental health records that he appeared to have a close and positive relationship with his mother.

11.3 Also in January 2015, while Kathleen was in refuge with Harbour[34] having presented as homeless in November 2014, she was referred into MARAC. Kathleen had told Harbour that her partner had pushed her, and she had fallen and had bruised her ribs. She also said her partner was isolating her from her friends and that he had previously thrown objects at her and that 'years ago' he had threatened to kill her.

Comment: *The partner was the man Kathleen had been with for many years. The MARAC considered the referral and subsequently took no further action.*

11.4 On 19th January 2015, Kathleen saw her GP primarily for a repeat prescription of anti-depressants. The GP recorded that she was due have an MRI scan of her nose having been punched by her former partner.

Comment: *Trevor told the review Chair that his mother and the former partner split-up at the end of 2014 and that after that time, she did not have another partner.*

There was no mention in the records of when Kathleen sustained her injury or of any discussion about domestic abuse or whether she was still in contact with her former partner. There was no mention either of any consideration of a referral to domestic abuse support services.

The IRISi programme[35] has now been implemented at this and other GP practices within Middlesbrough. A recommendation from this review is that the Middlesbrough Community Safety Partnership works with Health Commissioners to ensure that the IRISi Partnership receives further investment and where possible that it is extended to other GP surgeries in Middlesbrough.

11.5 During a CPA review in July 2015, Trevor said he was very happy in his flat and that his mother was visiting him regularly. He added that he was coping well with day-to-day bills and expenses.

[34] https://www.myharbour.org.uk/

[35] https://irisi.org/. IRISi is a training, referral and advocacy model aimed at helping clinicians to better support patients affected by domestic abuse and to increase awareness of it within general practice. It provides a direct referral route to a named advocate in a local specialist domestic abuse service who will also be available to provide ongoing advice to staff within the GP practice.

11.6 2016

11.7 In 2016, Kathleen's GP referred her to the Mental Health Access Team with a history of anxiety and depression. Kathleen said she was remembering events from the past about an abusive relationship (with an intimate partner) and issues such as being in foster care. The referral was discussed in the Multi-Disciplinary Access Team meeting where it was agreed that Kathleen would benefit from Talking Therapies[36]. (The service then tried unsuccessfully to contact Kathleen on several occasions).

11.8 Kathleen saw her GP again on 6th April 2016 with depression. The GP recorded, 'Past issues - says she is remembering bad things that happened in the past, issues about an abusive relationship she was in for 16-years, issues about being in foster care'.

11.9 On 20th June 2016, the police received a report about a woman carrying a knife in the street. When officers arrived, they found Kathleen intoxicated. She apologised and showed the officers where she had put the knife. She was arrested and when interviewed, admitted having the knife, saying she had to walk about 200-yards between her home and her son's home and that several youths in the area had made her feel intimidated. Kathleen was formally cautioned[37] and was then released from custody.

11.10 On 20th July 2016, Trevor called the police to report that an unknown male and female had been making threats towards him, but they had now gone. There was no requirement for the police to attend, but the following day they telephoned him back. Trevor told them there had been no further issues and that he would contact the police again should he feel the need.

11.11 Kathleen had another appointment with her GP on 1st August 2016 for a repeat prescription. Kathleen said she still felt anxious, and it was recorded that she said she had bought codeine from the street and that she said she was addicted to it.

Comment: *There is no mention in the records of any conversations with Kathleen about being referred to drugs and alcohol services. The notes do not make it clear what had caused Kathleen's anxiety.*

[36] Talking therapies are aimed at helping people overcome depression and anxiety and to better manage their mental health by talking to trained professionals about their thoughts, feelings, and behaviour. There are many different types of talking therapy, but they all aim to provide a patient with a safe time and place to talk and to make sense of things.

[37] A caution is a formal warning that may be given by the police to someone 18 or over who admits an offence. It is a means of dealing with low-level offending without a prosecution.

11.12 ## 2017

11.13 During 2017, Trevor attended his GP practice for mental health and medication reviews, and it was concluded that he was doing well and that he was having regular blood tests because he was being prescribed Clonazepam[38].

11.14 Trevor engaged with the mental health nurse which included care planning and wellbeing reviews and in addition he attended a Clozapine clinic every four-weeks. He also attended physical health monitoring meetings without concern. His mental health remained settled, and Trevor said he was not having any paranoid thoughts and had no feelings of low mood. It was recorded that Trevor stated he was happy to take his medication and that he believed Clozapine had helped his clinical recovery.

11.15 ## 2018

11.16 At an annual review in January 2018, Trevor said he was not having any paranoid thoughts and that he was not feeling low in mood. He was pleasant and displayed good eye contact throughout. The record stated that Trevor had demonstrated his ability to remain well, to further progress his insight and to remain drug free and that he was aware that to maintain good progress he must adhere to his treatment regime and care plans.

Comment: *After he had killed his mother, Trevor told psychiatrists that he had been taking cocaine and cannabis since 2017 and had managed to hide the fact from medical professionals.*

11.17 Trevor attended a Clozapine clinic monthly between 12th February 2018 and March 2019 (nine-days before he killed Kathleen). There were no signs of relapse recorded at any of them and the only negative medical indicators was Trevor suffering from excessive salivation on occasions (for which he was medicated). On each occasion blood samples were obtained, and he returned a 'green' result[39] and appointments were made for him to return to the clinic four-weeks later. On 4th June 2018, the Clozapine clinic notes indicated that Trevor disclosed drinking 'two to four pints' [of lager] per week and on 26th September 2018, he said his mental health had been stable since 2009 and that it had been due to his medication, but also because he had avoided drinking too much alcohol and that he was

[38] Clonazepam belongs benzodiazepine group of medicines. It is used to control seizures or fits due to epilepsy, involuntary muscle spasms, panic disorder and sometimes restless legs syndrome.

[39] A traffic light system is used to direct action in response to white blood cell levels. A 'green' result indicates the blood test is within usual parameters and so Clozapine can be continued.

not using illicit substances. On 22nd October 2018, it was recorded that Trevor denied using any illicit substances and that he was enjoying 'a few cans of lager', and on 14th January 2019 and 11th February 2019 it was recorded that he was drinking 'four or five cans [of lager] per week'.

Comment: *Trevor told the review Chair that he was fed-up with the excess salivation and that it caused his feet to shake, so about four-days after his final attendance at the Clozapine clinic, he decided to stop taking his medication, in the full knowledge that doing so would make him poorly again.*

11.18 On 17th April 2018, Kathleen told the Thirteen Housing Group[40] that she was struggling with utility bills and that she was depressed. She was referred to their Money Advice and Support to Stay teams and she said she felt she would benefit from counselling for her low mood and her financial problems.

11.19 On 29th May 2018, Kathleen saw her GP. She was anxious and it was recorded that she had a history of domestic abuse 'over a year ago' which had resulted in chronic rib pain. The plan included an x-ray (the results were normal) and she was prescribed Sertraline[41]. A diagnosis of 'Generalised anxiety disorder' was recorded.

Comment: *There is no mention in the notes of any discussion with Kathleen about domestic abuse or whether her anxiety was related to it. The lack of domestic abuse considerations and of not following-up on trauma informed counselling for Kathleen has been taken up with the GP Practice by the Clinical Commissioning Group because of this review. As mentioned previously, the IRISi programme has now been adopted by this GP practice.*

11.20 In September 2018, Kathleen attended her GP practice again. The GP recorded that Kathleen had said she had been the victim of domestic abuse until five-years ago. She added that she had been assaulted by her former husband, but that she hadn't told the police about it because she was frightened. It was also recorded that she had chronic back pain "*from years of physical abuse*". The plan included her seeing the practice physiotherapist and she was given the contact details for My Sisters Place for advice about domestic abuse.

Comment: *As mentioned previously, according to Trevor, his mother was never married.*

[40] Thirteen Housing Group Limited is a registered provider of social housing, operating predominantly in the Tees Valley, providing affordable housing based on individuals' housing need. Thirteen has a range of services to support tenants to sustain their tenancies, including money advice and Universal Credit support.

[41] Sertraline is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs). It used for the treatment of both depression and anxiety disorders.

11.21 On 3rd October 2018, Trevor attended his GP practice for a repeat prescription. The medical notes indicate he appeared anxious and that his self-care was okay.

Comment: *The medical notes are brief, and nothing was recorded about the cause of his anxiety or whether there was any consideration around liaising with the mental health team about it.*

11.22 On 9th October 2018, Trevor attended a review appointment with the consultant psychiatrist. He said he had been doing well with his mental health ever since he started taking Clozapine in 2008, adding that his main problem was hypersalivation which was happening mostly at night. It was recorded that Trevor was well kept and well-presented and that there was no objective evidence of any mood, thought or perceptual abnormalities. Trevor was prescribed medication for the salivation as well as his Clozapine.

11.23 Trevor attended the practice for his prescription again on 10th December 2018. The medical notes confirmed that his anxiety was controlled, that he was having regular reviews at the Clozapine clinic, that his mental health was settled and there were no concerns.

11.24 ### 2019

11.25 The last face-to-face consultation Trevor had at his GP surgery was for a medication and mental health review on 11th February 2019. He said he was not using alcohol to excess (six cans a week) and that there were no concerns around his mental health. As mentioned previously, Trevor's last attendance at the Clozapine clinic was in March 2019, just nine-days before he killed Kathleen.

12. ANALYSIS

12.1 To aid analysis against the review Terms of Reference, key events have been summarised below:

12.2

2000 to 2004	Aged 16, Trevor first told professionals about his odd beliefs and ideas – that he had stabbed his mother and had then sucked her blood and that he had attacked his mother's partner. Trevor cautioned for an attempted sexual assault on a female psychiatrist. First diagnosed with paranoid schizophrenia
2005	Assessed as posing a 'high-risk' of causing serious harm to others and referred into MAPPA.

2006	Detained under Section 3 Mental Health Act 1983 (From September 2006 to August 2009)
2008	Recorded that a doctor and a social worker intended to visit Kathleen to ask about Trevor's violence and to tell her that he may pose a risk to her in the future. (No record of the visit taking place)
	Transferred to medium secure conditions and prescribed Clozapine.
2009	MAPPA screening panel determined Trevor could be managed by a single agency and recommended the Care Programme Approach
	Began community care (August 2009 to March 2019)
2010	Care coordinator intended to determine relationship dynamics between Trevor and Kathleen. (No record of that happening)
2014	'FACE' Risk Assessment identified 'Staff, public and parent' as potentially at risk of harm from Trevor.
	Kathleen presented to Harbour as homeless.
2015	Kathleen referred into MARAC.
	Kathleen's GP recorded she had disclosed she had been punched by her former partner.
2016	Kathleen disclosed historic abuse by an intimate partner to her GP. Referral discussed by Multi-Disciplinary Access team which agreed she would benefit from Talking Therapies
	Kathleen arrested for possessing a knife.
	Kathleen told her GP she was anxious and that she was addicted to codeine.
2017	Mental health and medication reviews concluded Trevor was doing well.
January 2018	Trevor attended the Clozapine clinic – No issues noted.
	Trevor said he was drinking one or two cans of lager per week and was not using illicit drugs.
February 2018	Trevor attended the Clozapine clinic – no change in mood or behaviour and 'mentally stable.'
March 2018	Trevor attended the Clozapine clinic – doing well and eating and sleeping fine.
April 2018	Trevor attended the Clozapine clinic – bright in mood and looking forward to going on holiday.
	Kathleen was referred to Thirteen Housing Group for help with utility bills.
May 2018	Trevor attended the Clozapine clinic – pleasant and amenable and maintained good eye contact.

	Kathleen told her GP she was anxious and mentioned domestic abuse 'over a year ago.'
June 2018	Trevor attended the Clozapine clinic – said he was not smoking or using illicit substances. Drinking 'two to four pints' per week
July 2018	Trevor attended the Clozapine clinic – no signs of relapse.
August 2018	Trevor attended the Clozapine clinic – pleasant and amenable with good eye contact.
September 2018	Kathleen told her GP that she had been the victim of domestic abuse 'until five-years ago'. To see physiotherapist and given contact details for My Sisters Place
	Trevor attended the Clozapine clinic – good conversation and eating and sleeping well.
October 2018	GP noted Trevor appeared anxious, but self-care was okay.
	Trevor told psychiatrist he was doing well because of the Clozapine. Well kempt and well-presented with no evidence of mood, thought or perceptual abnormality.
November 2018	Trevor attended the Clozapine clinic – bright and chatty and eating and sleeping okay.
December 2018	GP recorded that Trevor's anxiety was controlled and there were no concerns with his thoughts or mental health.
	Trevor attended the Clozapine clinic – facially bright/chatty and eating/sleeping okay.
January 2019	Trevor attended the Clozapine clinic – Interacted well with staff. Said he was okay and had a good diet/fluid intake and was sleeping well.
February 2019	Trevor told his GP he was not using alcohol to excess (six cans a week), and he had no concerns around his mental health.
	Trevor attended the Clozapine clinic – interacted well, said he was okay and had a good diet and fluid intake and was sleeping well.
March 2019	Trevor attended the Clozapine clinic – settled in mood/manner and pleasant/amenable.
	Kathleen killed by Trevor.
July 2019	Trevor was convicted of Kathleen's manslaughter and was sentenced to a hospital order.

12.3 ## The Terms of Reference

Each Term or Reference appears in bold italics and is examined separately. Commentary is made using the material from the Individual Management Reviews, the two parallel reviews, the interview with Trevor and the Domestic Homicide Review Panel's debates. Some material would fit into more than one term and where that happens a best fit approach has been taken to avoid unnecessary duplication.

12.4 **TOR 1**

- ***Whether the incident in which Kathleen died was an isolated event and whether there were any warning signs***

12.5 There is no evidence that Kathleen had been the victim of any form of abuse from Trevor since the early 2000s. Trevor's medical records did not reflect any deterioration in his behaviour or presentation to indicate a relapse in his mental health prior to him attacking Kathleen and there were no warning signs that he was likely to do so. Given that the abuse that did take place was in the early 2000s and that there had been no indication since then of a relapse in Trevor's condition there is noevidence to suggest he had committed an offence against his mother since the serious attack in 2002.

12.6 **TOR 2**

- ***What knowledge each agency had that indicated Trevor might be a perpetrator of domestic abuse towards his mother***

12.7 Trevor had an extensive psychiatric and forensic history that included details of the time he had stabbed Kathleen and had sucked her blood around 2002 - and the fact that in 2008 Trevor had told mental health professionals that since an early age, he had harbored thoughts of killing her. However, there was no information held by any agency (other than mental health and GP services) in Middlesbrough that Trevor posed any sort of risk to Kathleen or that he posed a risk of being a perpetrator of domestic abuse because he was consistently assessed by mental professionals as being mentally stable and of posing a low risk of relapse.

12.8 Trevor's GP notes confirmed his mental health history, his past heroin addiction, and the fact he had been subject to MAPPA in 2009, (although the reason was not documented). The review panel have been told that because Trevor and Kathleen lived separately and attended different GP practices, there was no realistic prospect of Kathleen's GP notes including details of the assault by Trevor dating back to the early 2000s or if there had been mention of it, that it would have been easily visible to practitioners. The observation was made during the review though, that had there been some reference to the historical events, it may have prompted a more robust follow-up. to the disclosures Kathleen made to her GP around her ongoing anxiety and need for counselling/support and her references to past domestic abuse.

Comment: *There is now a process in place to inform GPs about risks relating to patients who are subject to MAPPA.*

12.9 **TOR 3**

- ***Whether local agencies should have known more about the history of abuse between Trevor and Kathleen.***

12.10 There was no reason for local agencies to have known more about the history of abuse between Trevor and Kathleen because he was not considered to pose a risk to her or to anyone else. Even if any agency had the information on record, there would have been no reason to access it. More than 15-years had elapsed since Trevor made the disclosures about attacking his mother and her partner (and his odd beliefs and ideas) and the team who were managing his care had known him for a very long time, so much so that they felt confident they would have identified quite quickly any significant change in his mental state - and if that happened, they would have raised an immediate alert. Post Kathleen's death, the team said there had never been any concerns around Trevor not being concordant with his medication. Trevor had presented as normal at the Clozapine clinic only nine days prior to attacking his mother and he told the review Chair (and mental health professionals) that he stopped taking his Clozapine only four-days before he killed Kathleen.

12.11 **TOR 4**

- ***Whether there were any barriers experienced by Kathleen or family/friends/colleagues in reporting any abuse in Middlesbrough or elsewhere, including whether they knew how to report domestic abuse should they have wanted to.***

12.12 Kathleen presented to Harbour as homeless in November 2014 and in January 2015 she was referred into MARAC having disclosed domestic abuse to Harbour by her partner. A few days later her GP recorded that she was due have an MRI scan of her nose having been punched by her former partner).

12.13 In 2016, the GP referred Kathleen to the Mental Health Access Team with a history of anxiety and depression after she described past events regarding an abusive relationship. The most recent time Kathleen mentioned domestic abuse was in May 2018, when she reported chronic rib-pain resulting from domestic abuse that took place 'Over a year ago' and then again in September 2018 when she told a GP that she had been the victim of domestic abuse 'For years, until five years ago'. She added then that a barrier to her reporting it to the police had been that she had been frightened. According to

Trevor, Kathleen and her long-term partner had ended their relationship around the end of 2014 and after that she was not involved with anyone else, so if Trevor is correct, the domestic abuse she was referring to must have been by the former partner.

12.14 There is a wealth of evidence[42],[43] that the impact on survivors of domestic abuse is significant and often long lasting and can include. anxiety, problems around employment and forming new relationships or friendships. Safe Lives research[44] found that almost 60 percent of victims identified in hospital had mental health concerns, just under half (49 percent) had post-traumatic stress disorder and 16 percent had been to an accident and emergency department having taken an overdose in the last six-months.

12.15 It appeared to the review panel that there may have been a lack of understanding of trauma within Kathleen's GP practice and how psychological and psychological symptoms of domestic abuse can be exhibited over a long period. Kathleen was a woman who was not working and who appeared to be very isolated, depressed, and anxious. There is no mention in Kathleen's GP records of any consideration around her being a vulnerable adult and whether she should be referred to adult social care or for trauma informed counselling. Kathleen requested counselling on more than one occasion, and she was given the contact details to enable her to self-refer into Talking Therapies, but the panel wonder whether a direct referral into the service by the GP may have been more appropriate. As mentioned previously, the IRISi programme has now been implemented at the GP practice and these issues should therefore not arise again.

12.16 Kathleen also told the Thirteen Housing Group that she wanted counselling for her low mood and her financial problems, but it appears that nothing came of it.

12.17 One (of the many) research findings that illustrate barriers that victims of domestic abuse face when considering disclosure stems from an Her Majesty's Inspector of Constabulary (HMIC) report from 2014[45]:

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42 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/thelastingimpactofviolenceagainstwomenandgirls/2021-11-24

43 https://www.safelivesresearch.org.uk/Comms/Psychological%20Violence%20-%20Full%20Report.pdf

44 SafeLives. (2016). A Cry for Health. Bristol: SafeLives. Available at: https://safelives.org.uk/cry-for-health

45 Everyone's business: Improving the police response to domestic abuse 27 March 2014 ISBN: 978-1-78246-381-8 www.hmic.gov.uk

'Many victims do not report their abuse. It is vitally important that police officers understand why this might be the case. Of those that responded to HMIC's open on-line survey, 46 percent had never reported domestic abuse to the police. The Crime Survey for England and Wales reported that while the majority of victims [79 percent] told someone about the abuse, for both women and men this was most likely to be someone they know personally [76 percent for women and 61 percent for men]. Only 27 percent of women and 10 percent of men said they would tell the police. The reasons the victims we surveyed gave for not reporting the domestic abuse to the police were: fear of retaliation [45 percent]; embarrassment or shame [40 percent]; lack of trust or confidence in the police [30 percent]; and the effect on children [30 percent]'

12.18 Kathleen explained to her GP that she had not reported the abuse to the police because she was frightened, but this does not appear to have been explored by the GP, so is not clear whether her fear was of the police themselves or, more likely, of retaliation by the perpetrator (the only known contact Kathleen had with the police was in respect of the incident when she had a knife).

12.19 An obvious barrier to Kathleen reporting any abuse or in her seeking help or advice from mental health professionals about Trevor was that it was likely she did not know who to contact or how to do it. There is nothing to suggest that Kathleen had the need to speak to them or that Trevor was abusive to her in the lead-up to her manslaughter, but nevertheless, given the history, she should have been provided with the necessary contact details. There was no record found of any mental health community team discussion about furnishing Kathleen with a means of contacting them or of them enquiring with her about Trevor's mental health, his behaviour towards her, his alcohol and illicit drugs use and his concordance with his prescribed medication.

12.20 **TOR 5**

- ***What safeguarding concerns in respect of Kathleen were considered throughout Trevor's contact with services?***

12.21 In addition to stabbing Kathleen in the early 2000s (and Trevor saying he had then sucked her blood), a 2008 nursing report recorded that Trevor had admitted several other physical assaults on her. It had also been noted that in 2006/7 Kathleen had featured in many of Trevor's bizarre delusions, such as that killing her would be followed by her rebirth, with him inheriting special powers.

12.22 Then, in early 2008 (and not long after it was recorded that Kathleen had said she was frightened of Trevor), it was noted that a doctor and

social worker had made arrangements to visit Kathleen to 'Ask about violence and communicate to her that he poses or may pose a risk to her in the future when in the community ... given the risk he poses, there is a view within the care team that such a disclosure is appropriate'. The records do not indicate that such a meeting ever took place, and the issue was not documented again.

12.23 Towards the end of his hospital stay, Trevor reportedly had unproblematic and positive contact with his mother. This continued when in the community from 2009 onwards, and there was nothing to indicate any short or medium-term risk of violence to her, at least for as long as his mental state remained stable. In late 2010, a care coordinator recorded that Trevor was willing to consider his mother being offered a carer's assessment, and the care coordinator recorded his intention to determine what the actual relationship dynamics were between Trevor and his mother. There is no evidence however that it was followed up and in fact there is no record of any contact between the community mental health team and Kathleen at any point between 2009 and 2019. As mentioned above, there was also no record of whether the issue of contact with his mother was discussed with Trevor and no record of any discussion within the team about the issue of Kathleen's potential vulnerability, specifically around any risk of violence from Trevor. From 2012, Kathleen was only mentioned in the records in the context of being Trevor's nearest relative/next of kin.

12.24 Kathleen's safety and vulnerability was not formally considered during Trevor's community care provided by adult mental health services. The nature of the ongoing relationship between Kathleen and Trevor was not enquired about sufficiently, if at all. Although it could be argued that the clinical teams did consider Kathleen's vulnerability during routine 'risk assessment and management', the review panel considers there should have been frequent recorded consideration or review about Kathleen's potential vulnerability and whether her vulnerability should have been escalated as a safeguarding concern.

12.25 **TOR 6**

- ***Whether, when Trevor was formally reviewed by community team members, there was evidence that they specifically explored or enquired about the issues of his unusual ideas about death/reincarnation, about possessing special powers, and about unusual ideas regarding his mother.***

12.26 Mental health professionals acknowledged that Trevor had a diagnosis of schizophrenia worsened by a long history of poly-drug misuse, and a social history indicative of poverty and deprivation. He lacked insight

and had a history of disengagement with services and non-adherence with prescribed medications.

12.27 Psychosis was regarded as the key issue in relation to risk. The 2019 safety summary notes included that for Trevor, substance misuse, disengagement from services and noncompliance with medication would likely be triggers to his relapse. It gave an historical account of the triggers and protective factors including his history of significant violence and risky behaviours and it noted the serious physical attack on his mother and her previous partner. Whilst the contents of the safety summary had not changed over time, it was monitored and reviewed at each review, and it was recorded that his presentation and risk-assessment had remained static.

12.28 In recent years, the contemporaneous notes recorded that Trevor's condition remained stable and gave a narrative of the conversation during the contact. None made specific reference to having explored or inquired about the issues of his unusual ideas about death/reincarnation, or about possessing special powers, and about unusual ideas regarding his mother, but what they did record was how Trevor presented himself. The staff and care coordinators were all familiar with Trevor, and they were confident that any changes to his presentation would have acted as a trigger for them to have alerted the lead professional so that a review could take place.

12.29 In January 2018 the annual review comprehensive care plan noted that in the event of Trevor ceasing his medication or receiving an adverse blood monitoring result, the consultant was to be alerted, an urgent medical review would be arranged, and increased contact would be made with Trevor to establish treatment and to prevent a relapse. His most recent review in January 2019 noted similar advice.

12.30 In addition, a contingency plan stated that on evidence of intrusive distressing hallucinations, illicit substance misuse, suicidal ideation, aggression or grandiose beliefs of superpowers, an urgent medical review would be arranged, and the team would consider the use of the Mental Health Act and if necessary, they would alert the police if a risk to himself or to others was evident. The reality was that because Trevor had demonstrated stability over such a long period of time and there had been no contra-indicators, any sign of a relapse of any sort would only have come to light upon his own admission; mental health professionals were therefore totally reliant on Trevor telling them the truth.

12.31 **TOR 7**

- ***Whether the most recent risk assessment included a complete list of Trevor's criminal offences and other assaultive behaviours?***

12.32 The most recent risk assessment did include a complete list of Trevor's criminal offences and other assaultive behaviours. The last risk-assessment was recorded in January 2019 and indicated that the risks remained low, and that Trevor had no thoughts of self-harm or of harming others (as did all the other risk assessments while Trevor was in the community). Letters about assessment results are routinely sent to a patient's GP, so had there been any changes to the risk, the GP would have been notified.

12.33 **TOR 8**

- ***If there were issues in relation to capacity or resources for agencies that impacted on their ability to provide services to Kathleen or Trevor, or their ability to work effectively with other agencies?***

12.34 None of the agencies involved with Kathleen or Trevor experienced any issues in relation to capacity or resourcing that may have impacted on their ability to provide services or to work effectively with each other.

12.35 **TOR 9**

- ***Whether the learning in this review appears in other domestic homicide reviews commissioned by Middlesbrough Community Safety Partnership?***

12.36 Middlesbrough Council has undertaken six DHRs since 2017. The first, which was conducted in 2017 and published in May 2019[46] had some similarities to this review as it related to an adult/child to parent homicide. The victim had been subjected to domestic abuse by her son for nine years, which began when he was an adolescent. In that and this DHR, the victims were relatively isolated. The respective DHR panels considered that the victims could potentially have been regarded as vulnerable adults, but neither were referred to adult social care, so no assessments of their care or support needs were undertaken. Neither of the victims engaged with or accessed local

[46] https://www.middlesbrough.gov.uk/media/1bzbt3gi/da-dhr1-report.pdf

domestic abuse services and they were largely unknown to other services in the area.

12.37 There were however significant differences between the two DHRs, not least of which was the known frequency of abusive behaviour to the victim by the respective sons – in Kathleen's case. There is no evidence that indicates that Trevor abused Kathleen in the fifteen-year period between when he was a teenager and when he subsequently killed her, whereas in the other case, domestic abuse by the son towards his mother was frequent. Another significant difference was the fact that it was known that Trevor was a paranoid schizophrenic who had been receiving mental health care for many years and who had been prescribed regular medication for it.

13. AGENCY KEY LESSONS LEARNED

13.1 TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST

13.2 An area of learning for the Tees, Esk and Wear Valleys NHS Foundation Trust was that Trevor's care plan did not accurately reflect how often he would be reviewed by the lead professional or the frequency of intended reviews.

13.3 On one occasion an entry within the clinical records (which described Trevor's presentation) had been 'copied and pasted' by a Clozapine clinic clinician from one appointment (14th January 2018) to another (11th February 2018). This was bad practice and was identified as an area of learning for the clinic staff.

13.4 KATHLEEN'S GP PRACTICE

13.5 Kathleen's GP Practice lacked professional curiosity in relation to whether she was still at risk of further domestic abuse from intimate partners. Kathleen had a long-term problem with anxiety and depression and although there is evidence of appropriate referrals being made, there may have been further opportunities to explore the cause of it which in turn could have led to a more open discussion about her home circumstances and her relationship with intimate partners and about Trevor and his current mental health status. There was no evidence of any consideration of whether Kathleen might have been regarded as a vulnerable adult despite her longstanding mental health problems and historical domestic abuse.

13.6 It was noted during the review that the GP Practice did not routinely display posters or provide any domestic abuse related leaflets within its reception, treatment rooms or toilets nor did they provide information or links about domestic abuse on their website. In addition, there were

no formal practice audits to monitor compliance with safeguarding activity such as record keeping and the identification of risk and appropriate referrals. The pilot of the IRISi programme and the adoption of it by the practice, in April 2022 will go a long way towards making sure that awareness raising of domestic abuse is given the priority it deserves[47].

13.7 TREVOR'S GP PRACTICE

13.8 The GP practice has mandatory safeguarding and domestic abuse training for its staff, but on reflection they feel an increase in the awareness of domestic abuse within the practice would be advised, including reinforcing professional curiosity, and increasing referrals through the IRISi programme.[48]

13.9 Although the practice had no reason to suspect that Trevor posed an ongoing risk of violence towards his mother, they do feel that a point of learning is that the historical violence that occurred in the early 2000s could have been referenced in their electronic medical records (SystmOne)[49].

14. CONCLUSIONS

14.1 Trevor had been in contact with mental health services for several years which included lengthy admissions to hospital whilst detained under the Mental Health Act. Following his discharge from hospital in 2009, he remained under the care of the Psychosis Community Mental Health Team, remaining on 'enhanced CPA' until December 2016. Trevor had remained mentally well during this time. The team caring for him were aware of his history and that the triggers for increased risk would be his dis-engaging from the service, non-concordance with medication and illicit substance misuse. There was no evidence of any of those triggers becoming apparent; Trevor had remained clinically stable (in terms of symptomatology and improved social and personal functioning) for many years prior to his attack on Kathleen. During the period of community supervision (2009 to 2019) there was no suggestion of any untoward behaviour by Trevor towards Kathleen, and no evidence of concerning beliefs. The level of risk posed by Trevor was justifiably assessed as being low as was the risk of a relapse, but the review panel noted with some concern that there was almost a total reliance on Trevor to provide whatever evidence there may have been.

[47] The GP Practice is due to complete further follow up training in June 2024
[48] Trevor's GP Practice is not currently a confirmed IRIS surgery.
[49] SystmOne is a clinical software system which allows health professionals access to secure, electronic information which details a patient's contact with health services, potentially across a lifetime.

14.2 After he had been arrested for murdering Kathleen, Trevor told mental health professionals that he had stopped taking his Clozapine and that he had been using cannabis and cocaine. He presented as acutely psychotic. Trevor told the review Chair that he was fed-up with the side effects of the Clozapine, namely excessive salivation, so about four-days after his final attendance at the Clozapine clinic, he decided to stop taking his medication, knowing it would make him poorly again.

14.3 It is the view of the review panel that the issue of the potential risk to Kathleen was not adequately addressed at any point after Trevor's hospital admission. In fact, it appears that the potential risk to her was not regarded as an active issue and that essentially, she failed to appear in Trevor's records (despite remaining an important person in his life). Staff did not ensure that Kathleen knew how to contact services in the event of a crisis - nor was there a record of any community team discussion about the relative merits of such an approach.

14.4 Bearing in mind Trevor's history and known circumstances (and what was known about Kathleen), it is concerning that mental health staff did not at any point document a discussion with Trevor about the potential benefits of involving Kathleen in his care arrangements. Equally concerning, is that there was no apparent consideration given to Kathleen's continued vulnerability or whether the potential for her coming to further harm from Trevor should have been escalated into a safeguarding concern.

15. RECOMMENDATIONS

15.1 MIDDLESBROUGH COMMUNITY PARTNERSHIP

15.2

- Review the evaluation of the two-year pilot of IRISi in Middlesbrough and write to the Integrated Health Board and Cleveland Violence Reduction Unit to make them aware of the benefits of the pilot, improved outcomes, and the risks in relation to sustainability of IRISi without collaborative commissioning, long term investment, or ownership of the initiative.
- Write to the Tees Esk Wear Valley to request written update and evidence that recommendations identified in this DHR have been addressed and that changes introduced in relation to policy and practice have been implemented.
- Identify partners in Community Safety Partnership and implement a communication plan on how learning and recommendations can be shared effectively across the partnership and monitor impact of this.

15.3

TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST

15.4

- A process should be put in place to ensure that potential victims of violence and abuse are provided with the means to communicate any concerns to professionals.
- Patient's care plans should accurately reflect the frequency of intended reviews and who is to conduct them.
- Written update and evidence provided to Community Safety Partnership that a previous recommendation that *'an audit be conducted to ensure there is no evidence of 'copy and pasting' of entries in clinical records by Clozapine clinic staff'* has been adequately addressed.
- Assurance should be provided that a previous recommendation that *'The Trust must revise internal policies and procedures relating to the functioning of 'Clozapine clinics' in order to be satisfied that any function relating to formal assessment of attendees' mental health status is clearly described and supported'* has been adequately addressed.

15.5

KATHLEEN'S GP PRACTICE

15.6

- Provision of domestic abuse help and support information should be available within the practice.
- Ensure staff are compliant with the Adult Safeguarding Roles and Competencies for Health Care Staff Intercollegiate Document and the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding accountability and Assurance Framework.
- Where Domestic Abuse markers are identified on patient records and/or concerns relating to potential domestic abuse are identified during consultations, appropriate enquires (for individuals aged 16 and older) should be considered to ensure that safeguarding concerns are identified and that correct procedure is followed.
- The GP practice should monitor appropriate safeguarding activity and policy compliance through record keeping audits and referrals.

15.7 TREVOR'S GP PRACTICE

15.8

- Where Domestic Abuse markers are identified on patient records and/or concerns relating to potential domestic abuse are identified during consultations, appropriate enquires (for individuals aged 16 years and older) should be considered to ensure that safeguarding concerns are identified and that correct procedure is followed.
- Ensure staff are compliant with the Adult Safeguarding Roles and Competencies for Health Care Staff Intercollegiate Document and the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding accountability and Assurance Framework.

Appendix A

MAPPA

The Criminal Justice Act 2003 established Multi-Agency Public Protection Arrangements (MAPPA). This is a process through which the Police, Probation and Prison Services work together with other agencies to help reduce the re-offending behaviour of violent and sex offenders living in the community to protect the public. The purpose of the arrangements is to ensure that comprehensive risk assessments are undertaken, and robust risk management plans are put in place. It takes advantage of co-ordinated information sharing across the agencies on each offender and ensures that appropriate resources are directed in a way that enhances public protection. There are three categories under which offenders are managed:

Level 1 cases

Ordinary agency management level 1 is where the risks posed by the offender can be managed by the agency responsible for the supervision or case management of the offender. This does not mean that other agencies will not be involved, only that it is not considered necessary to refer the case to a level 2 or 3 MAPP meeting. It is essential that information sharing takes place, disclosure is considered, and there are discussions between agencies as necessary. The Responsible Authority agencies must have arrangements in place to review cases managed at level 1 in line with their own policies and procedures.

Level 2 cases

Cases should be managed at level 2 where the offender is assessed as posing a high or very high risk of serious harm or the risk level is lower but the case requires the active involvement and co-ordination of interventions from other agencies to manage the presenting risks of serious harm, or the case has been previously managed at level 3 but no longer meets the criteria for level 3 or Multi-agency management adds value to the lead agencies management of the risk of serious harm posed.

Level 3 cases

Level 3 management should be used for cases that meet the criteria for level 2 but where it is determined that the management issues require senior representation from the Responsible Authority and Duty-to-Co-operate agencies. This may be when there is a perceived need to commit significant resources at short notice or where, although not assessed as high or very high risk of serious harm, there is a high likelihood of media scrutiny or public interest in the management of the case and there is a need to ensure that public confidence in the criminal justice system is maintained.

MAPPA guidance states: 'The central question in determining the correct MAPPA level is: What is the lowest level of case management that provides a defensible Risk Management Plan?'

FEBRUARY 2023 Updated FEBRUARY 2024 & APRIL 2024

Appendix B

DHR-5 Action Plan Middlesbrough Community Safety Partnership

The Action plan is a live document and subject to change as outcomes are delivered.

No	Recommendation	Scope	Actions to take Lead Agency	Lead Person, role & Agency	Key Milestones achieved in enacting the recommendation	Target Date	Completion Date
Middlesbrough Community Safety Partnership							
1	Review the evaluation of the two-year pilot of IRISi in Middlesbrough and write to the Integrated Health Board and Cleveland Violence Reduction Unit to make them aware of the benefits of the pilot, improved outcomes, and the risks in relation to sustainability of IRISi without collaborative commissioning, long term investment, or ownership of the initiative.	Local	Evaluation report completed by My Sisters Place and approved by IRISi Steering Group Report to be shared with CSP. MSP will contact Chair of Cleveland Violence Reduction Unit and request IRISi is included on agenda. CSP will request IRISi is included on agenda for Integrated Health Board Funding secured to sustain project for one year until agreement reached regarding long term investment.	Lesley Storey CEO MSP CSP Lesley Storey CEO MSP CSP Chair Erik Scollay DASP Chair Claire Moore DA Strategic Lead	Written evidence of the financial and social return in investment in IRISi so CSP can drive communication and influence commissioning investment decisions. Long term Investment in pathways from primary care to DA services Ensuring DVA is more visible in primary care settings and is given high priority. Improve knowledge and confidence of primary care staff increasing referrals, ongoing engagement, and quality of consultations in relation to issue.	January 2023	June 2023

No	Recommendation	Scope	Actions to take Lead Agency	Lead Person, role & Agency	Key Milestones achieved in enacting the recommendation	Target Date	Completion Date
				Middlesbrough Council	Consistent response locally and regionally which is compatible with local DA systems and process		
2	The Community Safety Partnership should write to the Tees Esk Wear Valley and request a written update and evidence that recommendations identified in this DHR have been addressed and that changes introduced in relation to policy and practice have been implemented.	Regional	CSP Chair will write to TEWV regarding the outcome of DHR so they can provide written update and evidence that recommendations Identified in DHR have been implemented	CSP Chair TEWV	TEWV will provide written assurance of the difference learning from DHR has made in facilitating improvements in community MH services and provide overview of audits which have taken place to ensure effective governance and monitoring of any changes	April 2023	March 2024
3	Identify partners in Community safety Partnership and implement a communication plan on how learning and	Regional	DA Strategic Lead will develop seven-minute briefing that will be published alongside reports and action plan. Multi agency virtual briefings will be arranged and disseminated. DHR-5 Learning will be shared at Community safety Partnership, Health	DA Strategic Lead	Learning and recommendations have been shared across partnership.	April 2023	March 2024

No	Recommendation	Scope	Actions to take Lead Agency	Lead Person, role & Agency	Key Milestones achieved in enacting the recommendation	Target Date	Completion Date
	recommendations can be shared effectively across the partnership and monitor impact of this.		and Well Being Board and other strategic and operational forums. DHR Learning and recommendations will be uploaded on Pentana MBC risk management system and reviewed by DHR scrutiny panel	CSP Chair			
Single Agency Recommendations **Tees Esk and Wear Valleys NHS Foundation Trust**							
1	A process should be put in place to ensure that potential victims of violence and abuse are provided with the means to communicate any concerns to professionals.	Regional	Trust to implement a audit schedule to review the quality and content of care plans.	TEWV	Trust to implement a audit schedule to review the quality and content of care plans.	Jan 2023	April 2023 QA8 - Community Matron Review - Fron QA5 - Community Quality Review - Fron
2.	Patient's care plans should accurately reflect the frequency of intended reviews and who is to conduct them	Regional	Introduction of a new electronic care record system (CITO) which includes goal-based interventions and reviews, including specific timescales and who is responsible	TEWV	To ensure reviews are based upon identified needs and personalised to each individual patient	July 2023 (CITO implementation 3rd	June 2024

No	Recommendation	Scope	Actions to take Lead Agency	Lead Person, role & Agency	Key Milestones achieved in enacting the recommendation	Target Date	Completion Date
						July 2023)	
3.	Written Update and evidence provided to Middlesbrough Community Safety Partnership that a previous recommendation 'an audit be conducted to ensure there is no evidence of 'copy and pasting' of entries in clinical records by Clozapine clinic staff' has been adequately addressed.		As Above.	TEWV	See action 1	Jan 2023	April 2023
4.	Assurance should be provided to Middlesbrough DHR scrutiny panel that a previous recommendation that 'The Trust must revise internal policies and procedures relating to the functioning of 'Clozapine clinics' in order		Trust to conduct policy review and create aide memoire for clozapine clinic staff.	TEWV	Policy to be reviewed. Evidence of new policy and ' clozapine checklist'	Jan 2022	Jan 2023  Clozapine Group Summary April 2022.  SMPG - Clozapine & Depots Focus Summa

No	Recommendation	Scope	Actions to take Lead Agency	Lead Person, role & Agency	Key Milestones achieved in enacting the recommendation	Target Date	Completion Date
	to be satisfied that any function relating to formal assessment of attendees' mental health status is clearly described and supported' has been adequately addressed.						 DTC Feedback March 2022.pdf  DTC Feedback September 2022.pdf  03 DTC May 2022 CONFIRMED Minutes.  05 DTC September DTC 2022 CONFIRME  Clozapine Group Summary February 2(

No	Recommendation	Scope	Actions to take Lead Agency	Lead Person, role & Agency	Key Milestones achieved in enacting the recommendation	Target Date	Completion Date
							 DTC Feedback May 2022.pdf  DTC Feedback July 2022.pdf  02 DTC March 2022 CONFIRMED Minutes.  04 DTC July 2022 CONFIRMED Minutes.

No	Recommendation	Scope	Actions to take Lead Agency	Lead Person, role & Agency	Key Milestones achieved in enacting the recommendation	Target Date	Completion Date
North East and North Cumbria Integrated Care Board							
1	**Kathleen's GP Practice** Provision of domestic abuse help and support information should be available within the practice	Patients and all practice staff	The IRIS programme has been piloted within this practice and relevant information posters have been provided and displayed	Victim GP Practice	To inform patients attending the surgery who may be subject to domestic abuse that support is available which may facilitate a disclosure during a consultation. The IRIS programme will support GPs, clinical and administrative staffs to improve their awareness and knowledge of domestic abuse. The objectives will be measured through monitoring numbers of domestic abuse safeguarding referrals made.	Dec 2020	June 2024
2	**Kathleen's GP Practice** The GP practice should monitor appropriate safeguarding activity and policy compliance through record keeping audits and referrals.	Safeguarding lead GPs and practice manager	The victims GP practice is part of a Primary Care Network who have employed a full time Safeguarding Lead who provides guidance and support to the GP practice relating to safeguarding activity which includes policies and safeguarding concerns being raised. Internal audits are undertaken by the practice senior administration staff.	Victim GP Practice	Effective governance and policy compliance is in place which will be measured through audit outcomes.	Dec 2020	On-going

No	Recommendation	Scope	Actions to take Lead Agency	Lead Person, role & Agency	Key Milestones achieved in enacting the recommendation	Target Date	Completion Date
3	**Kathleen and Trevor's GP Practice** Ensure staff are compliant with the Adult Safeguarding Roles and Competencies for Health Care Staff Intercollegiate Document and the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding accountability and Assurance Framework.	All practice staff	The practice manager is aware of the intercollegiate document and training requirements. The practice source the appropriate level of training for individual staff roles within the practice.	Victim GP Practice	All practice staff will receive adult safeguarding training relevant to their role as outlines in the intercollegiate document. This will be measured through staff training compliance figures.	Dec 2020	On-going
5	**Kathleen and Trevor's GP Practice** Where Domestic Abuse markers are identified on patient records and/or concerns relating to potential domestic abuse are identified during consultations, appropriate enquires (for individuals	GPs all clinical staff and practice manager	The practice to undertake audits of clinical records which should include auditing actions taken where domestic abuse markers are on patient records.	Perpetrator GP Practise	Effective governance and policy compliance is in place which will be measured through audit outcomes	Dec 2020	On-going

No	Recommendation	Scope	Actions to take Lead Agency	Lead Person, role & Agency	Key Milestones achieved in enacting the recommendation	Target Date	Completion Date
	aged 16 and older) should be considered to ensure that safeguarding concerns are identified and that correct procedure is followed.						
6.	The learning and recommendations from this DHR to be shared with primary care providers across Tees valley	GP practices	To disseminate learning across primary care practices within Tees valley	ICB	The learning from this DHR will facilitate an improvement of available information on primary care records and increase awareness of domestic abuse referral pathways. Individual practices will need to undertake their own audits to ensure effective governance and policy compliance is in place. The ICB will monitor, through the regional domestic abuse partnership meetings, numbers of domestic abuse safeguarding referrals made by primary care.	March 2023	March 2024

Appendix C

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Claire Moore
Domestic Abuse & Sexual Violence Strategic Lead
Middlesbrough Council Town Hall
Municipal Buildings,
Middlesbrough T
S1 3LB

25th April 2024

Dear Claire,

Thank you for resubmitting the report (Kathleen) for Middlesbrough Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in April 2024.

The QA Panel commended some aspects of the report. It was positive that the CSP offered condolences to the family of Kathleen and that advocacy was offered. There was good representation on the panel, including a domestic abuse specialist and a forensic consultant phycologist, which provided a helpful insight into Trevor's mental health and his risk to Kathleen. It was also positive to note that the author interviewed the perpetrator, especially in light of limited input from other family or friends.

The QA Panel noted that most of the issues raised in the previous feedback letter following the first submission have now been addressed.

The view of the Home Office is that the DHR may now be published.

There are some areas of the development that the QA panel would like you to note.

- The Equality and Diversity Section (page 13 - 14) remains unchanged. There are no additions and remains underdeveloped. Instead, the statistics and research addition has been added to Section 9 Strategic Governance and Definitions on page 15 paragraph 9.5. The highlighted additional paragraph here cites statistics from DHR research October 2019 to October 2020 which is incorrectly dated and it has not been referenced in a footnote or elsewhere nor is a weblink given. The correct date of this research is October 2019 to September 2020. The statistics used have simply been reproduced wholesale from the research. There is no attempt to put them into context. It would benefit the review and have more significance it the data relevant to this case was used to highlight risk in family abuse cases i.e. data showing the

propensity of adult family domestic abuse cases to be committed by an adult child notably by sons, particularly of mothers (i.e. matricide). Matricide has not been discussed or named. Giving relevant context for the data to this case would increase learning among practitioners and alert them to considering risk in their assessments.

- Footnote 12 page 14 does not access the relevant site. The following message appears ‘This www.middlesborough.gov.uk page can’t be found. The needs to be corrected.

- The weblink in footnote 14 on page 15 does not work - it no longer exists, possibly because it is old data from 2018. Another more up to date reference should be used to enable the reader to follow up the research.

- Further research has been added to paragraphs 9.13 and 9.14 under the sub-heading of Abuse of Parents by Their Children. However, footnote 16 on page 17 does not lead to the Home Office document cited quoting from paragraph number 1.4 of that document in paragraph 9.12, it leads to the Home Office webpage ‘How to Get Help’. The correct website leading to the document quoted needs to be inserted.

- Footnote 17 on page 17 does not lead to the Standing Together report cited in paragraph 9.13.

- Page 33 footnote 39 – link does not work. Copying and pasting the link produces the Safe Lives website, but Page no Found message. Please correct.

- Page 39 Learning for the victim’s GP practice: There are no dates included for when the IRIS pilot took place or when IRIS was formally adopted by the GP practice. These should be inserted to confirm and instil confidence that these actions have taken place.

- Paragraph 8.3 does not require the words mid-50s and mid-30s. Please amend the sentence to: “Kathleen was 55 years old when she was killed, and her ethnicity was white British. Trevor was 34 years old when he killed his mother, and he is also white British.

- Page 39 Learning for the victim’s GP practice: There are no dates included for when the IRIS pilot took place or when IRIS was formally adopted by the GP practice. These should be inserted to confirm and instil confidence that these actions have taken place.

- It is not accurate to state “it is considered fair to say that the incident in which Kathleen died was an isolated event”. It would be more correct to say there was no evidence to suggest he had committed an offence against his mother since the serious attack in 2002. It cannot accurately be considered ‘an isolated event’ if the perpetrator had been

violent to the victim before even if it was some 17 years ago. The suggested alternative wording is still recommended.

- The Conclusions and recommendations in the Executive Summary differs from the Overview Report. There should be consistency between the two; they should be the same in each document.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,
Home Office DHR Quality Assurance Panel